Highmark's Weekly Capitol Hill Report

Issues for the week ending December 5, 2025

Federal Issues

Legislative

ACA Remains a Focus in Closing Days of Session

With only two weeks to go in its 2025 legislative session, all eyes are on the Senate's planned vote this Thursday to extend the Affordable Care Act's enhanced health care tax credit.

Senate Majority Leader John Thune (R-SD) promised the Democrats a vote as part of a deal to end the government shutdown last month and they intend to offer a clean, three-year extension of the enhanced premium tax credits.

Meanwhile, GOP leaders are still finalizing a plan to potentially use as an alternative. There has been a growing sentiment among GOP members that some action is needed but there appears to be little consensus within the party on the best path forward.

Other related activity on the Hill last week includes:

- A Senate HELP Committee hearing Wednesday on affordability at which the ACA tax credits took center stage. Both parties agreed there is an urgent need for a short-term

In this Issue:

fix to avoid coverage disruptions while pursuing long-term market reforms, however there was no bipartisan consensus on the best policy.

- House Speaker Mike Johnson (R-LA-04) signaled a forthcoming GOP health care plan that likely excludes eAPTC extension. House Minority Leader Hakeem Jeffries (D-NY-08) released a Dear Colleague urging his democratic colleagues to prioritize affordability and extend the eAPTCs for three years, criticizing Republicans for ignoring rising costs.

- Senators Lisa Blunt Rochester (D-DE) and Ron Wyden (D-OR) introduced legislation to extend the eATPCs for three years, extend the 2026 Open Enrollment period, reinstate automatic reenrollment and navigator funding, streamline enrollment for families, and lower out-of-pocket costs.

- The Government Accountability Office (GAO) released early findings demonstrating long-standing fraud risks continue to persist in the ACA Marketplace, including the ability to obtain subsidized coverage for fictitious enrollees and questionable Social Security numbers that may signal identity fraud. However, the report uses old data and fails to acknowledge recent safeguards like tougher eligibility checks, stricter broker oversight, and new CMS rules to protect consumers.

- Ways and Means Committee member Aaron Bean (R-FL) hosted his inaugural Path to Consensus series, aimed at addressing the broader debate surrounding America's healthcare system. The event featured two panel discussions: one on competition and choice, and another on the expiring eAPTCs. The tax credits panel featured AHIP's President and CEO Mike Tuffin advocating for extending the eAPTCs with reforms, including program integrity, income caps, and codifying ICHRAs. Ryan Long of the Paragon Institute argued for

Pennsylvania

Regulatory

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allowing the tax credits to expire, focusing instead on HSA expansion and funding cost-sharing reductions.

What's next: Only 10 legislative days remain for Congress to reach a deal on the ACA, though debate could spill into January ahead of the Jan. 30 government funding deadline.

Federal Issues

Regulatory

HHS Finalizes Federal Medical Assistance Percentages for 2027

The Department of Health and Human Services (HHS) reissued final federal Medical Assistance Percentages (FMAP), Enhanced Federal Medical Assistance Percentages (eFMAP), and disaster-recovery FMAP adjustments for fiscal year (FY) 2027.

Why this matters: These FMAPs will be used to determine federal matching payments for Medicaid and the State Children's Health Insurance Program (CHIP). HHS is required to adjust and publish these FMAPs every year using formulas set out in sections 1905(b) and 1101(a)(8) of the Social Security Act and calculations from the Department of Commerce of average income per person in each state and for the United States. Percentages for the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are specified in statute, and thus are not based on the statutory formula that determines the percentages for the 50 states. Read More

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HHS Repeals Nursing Home Minimum Staffing Standards

The Centers for Medicare and Medicaid Services (CMS) published the official version of an Interim Final Rule (IFR) which repeals certain provisions of the Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule issued in April 2024.

H.R. 1 placed a moratorium on the implementation of several provisions in the 2024 Rule. The provisions imposed minimum quantitative staffing standards for long-term care facilities participating in Medicare and Medicaid, including requirements for a registered nurse to be onsite 24 hours, 7 days per week and a minimum number of nurse staffing hours per resident day. The legislation prevents CMS from implementing or enforcing the provisions until September 30, 2034. The IFR rescinds these requirements entirely and reinstates nursing standards that were in effect prior to the 2024 Rule.

CMS estimates the changes to these provisions will result in savings of $55 billion to nursing home providers over 10 years and a cost to Medicare of $3.2 billion over 10 years.

The IFR provides a comment period through February 2, 2026. However, because it is an IFR, the changes will be effective on February 2.

CMS Unveils Medicare Advantage, Part D Proposals for 2027 Products

CMS recently released a proposed technical rule and fact sheet outlining policy updates and other technical changes to the MA and Part D programs for 2027.

Why this matters: Finalized policies in the proposed rule, along with an upcoming 2027 advance notice/rate announcement, are critical as Plans develop MA and Part D products for bid submissions due in June 2026.

The details: Some of CMS' proposals include:

- **Eliminating** the Excellent Health Outcomes for All (EHO4all) Reward, formerly called the Health Equity Index — a proposal BCBSA supports since many high-performing MA plans serving vulnerable populations were ineligible.
- **Updating** Star Ratings by eliminating 12 administrative measures to better focus on care, outcomes and patient experience. CMS also proposes adding two MA measures in 2027 for behavioral health to be reflected in the 2029 Star Ratings.
- **Removing** a rule requiring MA plans to send members a mid-year notice about unused supplemental benefits because more members are using these benefits than expected. Sending the notice could confuse beneficiaries and is especially hard for smaller MA plans.

Yes, and: CMS is seeking further input on future policy development, potential refinement to the Stars program and risk adjustment approaches that advance competition and foster a level playing field for smaller, regional MA plans. Feedback could lead to improvements in the MA program through pilot programs or program changes.

This signals a recognition by CMS that:

- The current risk adjustment program must evolve to promote fair competition across all plan types, reduce opportunities for gaming and limit administrative burden.
- The Star Ratings process must be streamlined to speed measure adoption, quality incentives should be better aligned, and beneficiaries need more timely, actionable quality information.

CMS Announces the Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model in Original Medicare

On Mon. Dec. 1, the Centers for Medicare and Medicaid Innovation (CMMI) announced the voluntary model to test an outcome-aligned payment approach designed to give beneficiaries under Original Medicare new options to improve their health and prevent and manage chronic disease with technology-supported care.

Why this matters: The voluntary model will focus on four clinical tracks addressing many of the most common chronic conditions. The model is anticipated to run for 10 years beginning on July 1, 2026. On Thurs. Dec. 4, CMS held a livestream event titled "Modernizing America's Care for Better Health" to inform stakeholders on ACCESS and to announce a collaboration with the Food and Drug Administration (FDA) and their "Technology-Enabled Meaningful Patient Outcomes (TEMPO) for Digital Health Devices Pilot".

BCBSA attended the CMS event as an early supporter of a new approach to delivering care to Original Medicare beneficiaries with chronic conditions. The model advances their long-standing support for value-based care and the adoption of technology to lower the cost of health care and improve the health care experience.

CMS Releases 2026 Home Health Prospective Payment System Final Rule

On Nov. 21, CMS released the CY 2026 Revisions to Payment Policies under Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System (CMS-1834-FC), as well as an accompanying press release and fact sheet. This Final Rule is in response to the July 15 Proposed Rule (CMS-1834-P). CMS also released a second fact sheet focused on hospital price transparency provisions of the OPPS.

State Issues

New York

Legislative

2025 Session End of Year Activity

Governor Hochul signed the bill requiring insurers to cover follow-up screening or diagnostic services for lung cancer with no cost sharing (**A.1195-A/S.2000-A**). Another bill impacting health plans, which would have mandated large group coverage of "backup" devices for patients with cochlear implants **(S.8265-A/A.6314-A**), was vetoed by the Governor. In her veto message, the Governor noted "the bill would increase the costs of health insurance coverage and insurers would likely build such costs into premiums, making health insurance less affordable."

There are still a few bills of interest that have not been sent to the Governor, including:

- **A.3319/S.1001** – Requires outpatient care provided by creative arts therapists be included in certain insurance policies.

- **A.3986-A/S.2105-A** – Requires health plans to provide notice of a fee when using a credit card, virtual credit card or other electronic fund transfers to make payments to a provider and offer an alternative that does not include fees.

- **A.7038-A/S.6897-A** – Requires the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) to publish a fee schedule for commercial health plans to utilize in reimbursing services for outpatient mental health and substance use disorder treatment at certain in-network facilities.

- **S.929/A.2141** – New York Health Privacy Act. A coalition of nearly 50 organizations, including the NY Health Plan Association and the Business Council of NYS requested a veto via a memo submitted to the Governor last week.

All 2025 passed legislation must be acted upon by the Governor by 12/31/25.

2026 Session Calendar Released

Last week the Legislative Calendar was released, with the session set to begin January 7 and run until June 4, and Governor Hochul announced that the State of the State has been scheduled for January 13. Shortly after the State of the State, the Governor will unveil her Executive Budget proposal in which the state will have to address expected shortfalls caused by cuts in federal funding under the One Big Beautiful Bill Act. The Governor last week continued to say raising income taxes was a "no-go," but didn't close the door on looking at "other revenue sources," which some observers believe could include increases in corporate taxes.

Regulatory

New York Regulatory

The Department of Financial Services late last week sent a 308 Letter to plans requesting information and supporting documentation from insurers and managed care organizations in connection with the DFS and Department of Health regulations that took effect on July 1, 2025 establishing appointment wait times and provider directory requirements for mental health and substance use disorder services.

The request applies to basically all comprehensive health insurance coverage – including municipal cooperative health benefit and student health plans – as well as commercial HMO and PHSP coverage; Medicaid managed care; Child Health Plus; and the Essential Plan.

Responses are due "no later than 15 business days" of the date of the letter, which is December 26. Recognizing that the timing for the response overlaps with the Christmas holiday week, DFS indicated that plans needing an extension should submit that request to health@dfs.ny.gov.

State Issues

Pennsylvania

Regulatory

Administration Releases 2025 Transparency in Coverage Report

The Pennsylvania Insurance Department released its annual Transparency in Coverage Report to continue its work to provide robust transparency into the health insurance claims process.

The report is intended to help Pennsylvanians better understand claims, claim denials, and appeals rights under their fully-funded health insurance policies on Pennie. It also highlights the most common reasons for denials and provides important website links related to TiC requirements for individual and small group plans in the Commonwealth that are subject to the Affordable Care Act (ACA).

During 2024, around 500,000 Pennsylvanians enrolled in plans in the individual market (Pennsylvanians who bought their own insurance) and submitted over 20.7 million health insurance claims. Insurers denied about 3 million of those claims, resulting in a claim denial rate of 14.8%, which is 3% less than the 2024 national claim denial rate of 17.8%.

The TiC Report found that:

- **The number of claims submitted by Pennsylvanians increased** 34% from 15.5 million (2023) to 20.7 million (2024);
- **The percentage of claims denied increased** from 13.8% to 14.8%, still below the national average. The aggregated claim denial rate has been relatively stable since 2020, between 12.6% and 14.8% of all claims received;
- **The percentage of overturned internal appeals dropped** from 48.4% to 35.7%.
- **Pennsylvania's internal appeal rate fell slightly.** Both Pennsylvania and national consumer internal appeal rates are below 1%.

DOH and Patient Safety Authority Publish MCARE Act Reporting, Shoulder Dystocia Harm Mitigation Guidance

The Department of Health and the Patient Safety Authority (PSA) released draft Medical Care Availability and Reduction of Error Fund (MCARE) Act reporting recommendations and finalized recommendations to mitigate harm from shoulder dystocia.

PSA Draft MCARE Act Reporting Recommendations

Last week, the Pennsylvania Patient Safety Authority (PSA) and Pennsylvania Department of Health (DOH) published draft and final recommendations in *Pennsylvania Bulletin* **Vol 55 Number 48**. Included in this release are draft updated guidance on MCARE Act reporting requirements for acute care facilities, and final recommendations to mitigate risk of harm related to shoulder dystocia.

Draft MCARE Act reporting recommendations include:

- Statutory definitions of reportable events
- New guidance on reporting standards and additional clarifications

- Amendments to previous guidance

The PSA, along with DOH, the Hospital & Healthsystem Association of Pennsylvania (HAP), and a multidisciplinary work group developed this guidance over the past year. These recommendations were approved by the PSA Board and the Pennsylvania Secretary of Health.

Comments are due by **Monday, December 29, 2025**.

PSA Finalizes Shoulder Dystocia Recommendations

Final recommendations to mitigate risk of harm related to shoulder dystocia have been released. These final recommendations include:

- Key themes
- Authority summary response to comments
- Original draft and final recommendations
    - Final recommendations provide guidance for training and competency, debriefing, and documentation
- Response to 38 public comments

During 2023, the PSA identified an increase in the occurrence of reportable harm events related to neonatal complications including shoulder dystocia. Subsequently, the PSA proposed reporting changes that would require hospitals to provide additional event details, some of which hospitals had concerns about. Those concerns led to a safe table discussion. The PSA Board then approved draft recommendations during the January 2025 board meeting. However, hospitals still had some substantive concerns and noted that they could not support that draft as written. After considering additional comments, the PSA and DOH further amended the guidance resulting in these final recommendations.

Why this matters: Hospitals are encouraged to review both sets of recommendations and determine if comments are warranted on the MCARE draft and if further pushback should be done on the shoulder dystocia final recommendations. Both documents could have significant impact on hospitals, especially if used as licensure standards during DOH surveys.

Industry Trends

Policy / Market Trends

KAC Underscores Urgency of EPTC Action

Keep Americans Covered (KAC) published a new article urging Congress to extend the enhanced premium tax credits (EPTC) before December 15, a key enrollment deadline for consumers signing up for 2026 coverage beginning January 1.

Background: Americans purchasing coverage on the federally-facilitated marketplace (FFM) through healthcare.gov have until December 15 – just under two weeks – to pick plans in order for coverage to take

effect on January 1. But families are still logging on and seeing skyrocketing premiums, by an average of 114%, because the EPTCs have not yet been extended.

It's Not Too Late: Many Americans face historic cost increases or the possibility of losing coverage altogether if EPTCs are not extended. Marketplaces also have the capability to swiftly revise the 2026 tax credit amounts available to consumers, ensure issuers receive revised net premium information to provide consumers updated premium bills, and conduct significant outreach and education to people who may have already terminated their coverage.

Action Needed: KAC and AHIP will continue to urge Congress to act as quickly as possible to maintain the health care tax credits, which will bring immediate relief to millions of Americans counting on the individual market for their 2026 coverage.

Go Deeper: See the impact of the EPTCs through KAC's cost calculator here and the state-by-state map here.

AHIP Urges Congress to Pair Tax Credit Extension with Additional Program Integrity Measures

AHIP called on Congress to take bipartisan action to preserve the health care tax credits and further strengthen program integrity following the release of a new Government Accountability Office (GAO) report alleging unauthorized enrollments and plan switching in the individual market.

The Bottom Line: AHIP made clear health plans believe continuous improvements should be made to protect consumers and taxpayers from potential fraud. AHIP's statement points out that plans have consistently supported additional safeguards, such as:

- Expanded multi-factor authentication for consumers, which is already used in state-based marketplaces;
- Bipartisan program integrity reforms currently under consideration in Congress; and
- Stronger eligibility checks as consumers move between Medicaid and Marketplace coverage.

Building on Existing Provisions: The activity in the GAO report predates substantial new provisions to strengthen program integrity that were included in the *One Big Beautiful Bill Act* and the Marketplace Integrity and Affordability Rule, including:

- Enhanced income-verification requirements
- More robust checks between Medicaid and Marketplace eligibility
- Ending automatic reenrollment
- Targeted limits on special enrollment periods

- Full repayment of excess tax credits
- Stronger oversight of agents and brokers

GAO acknowledges CMS already took decisive action in response to complaints of unauthorized enrollments and plan switches in 2023-2024, the very problems highlighted in the GAO analysis. Once implemented, CMS policies drove a **significant decline** in unauthorized activity. Moreover, as GAO acknowledges, the report's findings "cannot be generalized to the overall enrollment population."

Go Deeper: Read more here from AHIP on how policymakers have already taken decisive action to prevent fraud in the marketplace.

AHIP Submits Recommendations to CMS on Medicaid Community Engagement Guidance

On December 2, AHIP submitted a letter to CMS Administrator Dr. Mehmet Oz on recommendations as the agency develops guidance on community engagement requirements. Topics addressed in the letter include:

- Ways in which states can partner with Medicaid Managed Care Organizations during implementation.
- The need for clear definitions and operational guidance.
- The importance of facilitating cost-effective approaches that minimize beneficiary burdens and limit inappropriate coverage losses.

Key Excerpt: "Taken together, these recommendations draw on the deep expertise and experience of MCOs, reduce uncertainty for states and other stakeholders, minimize erroneous disenrollments, and make potential technology solutions as scalable and cost-effective as possible. AHIP and its member organizations look forward to collaborating with states and CMS to support these efforts."

Go Deeper: See AHIP's detailed toolkit for states to use in implementing the Medicaid community engagement requirements.

MedPAC, MACPAC Release 2025 Duals Data Book

The Medicare Payment and Access Commission (MedPAC) and Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) released their Beneficiaries Dually Eligible for Medicare and Medicaid Data Book. The data book shows that there were 13.6 million people who were dually eligible for Medicare and Medicaid for at least one month in 2022. Combined spending on dual eligibles was $548.8 billion in CY 2022. Duals also accounted for a disproportionate share of spending for each program, totaling 20% of the Medicare population but 36% of Medicare spending and 13% of the Medicaid population and 27% of Medicaid spending. Read More

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New York Legislation: **https://nyassembly.gov/leg/**
Pennsylvania Legislation: **www.legis.state.pa.us.**
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